MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

**Thursday, September 12, 2002**
**10:14 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

**AGENDA ITEM: The social HMO (S/HMO) demonstration project -- Tim Greene, Scott Harrison**

MR. GREENE: The Deficit Reduction Act of 1984 established guidelines for a demonstration of the social health maintenance organization, also called S/HMO. HCFA initiated the demonstration in 1985 and the Congress extended the demonstration five times between 1987 and 2000. The demonstration is currently scheduled to continue. CMS has extended it through December 2003, and legislation passed by the House would extend it through December 2004.

The Balanced Budget Act of 1997 required the Secretary to submit a report to the Congress that addresses transitioning S/HMOs and similar plans to the Medicare+Choice program. He submitted this report on February 1st, 2001 and is preparing a final report on the demonstration now. The Balanced Budget Refinement Act of 1999 required that MedPAC submit a report to the Congress containing recommendations regarding the project no later than six months after the Secretary submits his final report. The CMS final report on the S/HMO demonstration is expected to be submitted to Congress this November.

The social health maintenance organization tests a managed care model intended to integrate acute, chronic, and long term care as well as social services through health maintenance organizations. All plans are paid on a capitation basis. They receive payments 5.3 percent greater than the Medicare+Choice county rate. That is 5.3 percent greater than the old AAPCC.

There are two social health maintenance organization models. Four first generation plans were started in 1985, as I indicated, and three continue in operation. Evaluation of this demonstration led to development of a new model. One second generation plan was started in 1996. Both S/HMO models are designed to integrate services through an expanded benefit package and care coordination. They offer three types of benefits, basic Medicare, expanded benefits such as drugs and eyeglasses, and home and community-based long term care.

All enrollees are entitled to basic and expanded benefits. In the S/HMO 1 plans, enrollees determined to be nursing home certifiable are entitled to long term care benefits. Case managers play a key role in allocating these benefits in the S/HMO 1. Benefits include things such intermediate nursing care, personal health aides, adult daycare and respite care.

One goal of the S/HMO 2 demonstration is to incorporate practices that geriatricians developed into the operations of a plan. These include measures such as comprehensive geriatric assessment for some patients, treatment of functional problems, and team approaches to care. In the second generation demonstration these benefits are not limited to the nursing home certifiable as in the S/HMO 1 but are provided to those with high risk conditions impending disability and disabilities.

Payments to the S/HMO plans are risk adjusted and the methodology varies by the model. The S/HMO 1 demonstration uses modifications to the payment factors in the demographic component

of the Medicare+Choice rates. The second generation S/HMO method is based on a regression model. Payment is determined by the presence of 10 chronic conditions, ability to perform four activities of daily living, and several other variables. These are MCBS variables.

CMS has exempted the S/HMOs from M+C risk adjustment and continues to explore alternative methods for reflecting frailty in the proposed comprehensive risk adjustment system.

As I indicated in the briefing material, in the tables there, enrollment in the S/HMO demonstrations increased greatly in recent years, from about 70,000 in December 1998 to about 108,000 in July of this year. Membership averages 27,000 per plan. However this really reflects two large plans and two much smaller plans. SCAN in Southern California has 52,000 and Health Plan in Nevada, the second generation plan, has almost 41,000. So this is 90 percent of the entire demonstration. Of course, S/HMO members are a very small share of the total Medicare beneficiary population. In addition, members are a very small share of each market area's population with the exception of the Health Plan of Nevada, the S/HMO 2 plan.

HCFA first evaluated the first generation sites in the 1980s. The second evaluation, focused on the S/HMO 2 site, is nearly completion. The first evaluation found that the first generation plans successfully offered long term care services but did not develop well-coordinated systems linking acute and chronic medical benefits. This is important, because as I indicated earlier, this was a key goal of the original demonstration, integrating acute and long term care. The principal problem was that the projects did not establish good working relationships between physicians and case managers. Physicians did not change practice style and remained uninvolved with participants.

Since the evaluation, the first generation plan in Portland, Oregon, the Kaiser plan has moved forward with integrating care more successfully, and preliminary results from the evaluation of the S/HMO 2 indicates some greater success in care integration.

The first evaluation found that the S/HMO plans varied in total cost, with some sites higher than fee-for-service and others lower. In addition, different cost components, physician, nursing home, and such, vary. Some are higher than fee-for-service and some are lower. Preliminary information from the evaluation of the second generation plan indicates no overall difference in service use between the S/HMO and Medicare+Choice plans in its market area. This doesn't directly address the question of cost or expenditures but it does suggest that costs do not differ between the Nevada plan and its neighboring M+C plans.

S/HMO members are generally no more frail than members of the M+C plans in the same market area. The evaluation found that based on measures of health and functional status, two of three first generation plans had case mix that does not differ from that of M+C plans. In addition, the health status of members in the second generation plan also does not differ from that of members of area M+C plans. The exception here is the S/HMO run

by Kaiser in Portland, a group model HMO. This HMO operates both a S/HMO and a regular M+C plan in the same market, which suggests that there may be a selection process of beneficiaries seeking or in need of greater care moving to the demonstration plan, and others selecting the conventional M+C plan.

The demonstration plans have mixed effects on health outcomes. First generation plans showed similar results as fee-for-service. There was no difference for case-mix standardized mortality between the S/HMO plans and traditional Medicare. Other measures of outcome were ambiguous; superior for some subpopulations compared to fee-for-service and not for other populations.

Preliminary results from the evaluation of the second generation plan show no greater improvement in member health and functional status than in M+C plans. Researchers concluded that there is no consistent evidence of positive effect of the S/HMO benefits on member physical, cognitive, or emotional health.

The Secretary is considering the future of the S/HMO demonstration. A report on transitioning the plans into Medicare+Choice presents two options; convert the S/HMOs into standard M+C plans at the conclusion of the demonstration or make the social health maintenance organization an alternative under the M+C program. The report recommended converting S/HMOs into standard M+C plans with a transition ending in 2007. Supplemental payments to S/HMOs would be phased out while comprehensive risk adjustment was introduced. In 2007, the S/HMOs would be paid entirely with M+C comprehensive risk adjustment.

The Secretary is not expected to make a recommendation in the final report on the demonstration. This is the report that you're required to formally respond to. CMS may not repeat the recommendation made by the previous administration in its February 2001 report on transitioning the S/HMO into M+C, either in the final report or elsewhere. We don't know whether the recommendations I've just described will be the ones that CMS will be presenting in the future.

MR. HACKBARTH: Tim, I'm not sure I followed that. So in February 2001 they said we ought to convert these into standard M+C plans?

MR. GREENE: Right.

MR. HACKBARTH: Then you're saying you don't know whether they will --

MR. GREENE: That's the last administration's recommendation so we don't know where they stand, and we can't tell from CMS staff contacts. So these are what we know but we just can't say for a certainty whether they're going to continue.

When the final report is available, staff will evaluate it and develop options for the Commission's response. We'll critically review the data used and the analytic methods employed. I could note in passing that there are major weaknesses in the evaluation of the S/HMO 2 which the CMS researchers readily acknowledge. That the evaluation was done as published, and even to some extent in the final form we'll see, based on a very early period of the second generation

demonstration before many of the components were in place and when they were still developing.

Secondly, in terms of methodology, researchers note that -- based their analysis on a comparison of the demonstration with a comparison group in the overall HMO. The comparison group was closed down in the middle of the evaluation period and they conclude from that that it's very difficult to reach firm conclusions. That's a methodological question we'll have to examine and consider. But the short of it is, the researchers are very conservative in their interpretation of the data and the methodology and we'll have to consider that in our response.

We will examine the options CMS considered and the recommendations it makes, both in February 2001 and anything further they come out with. BBRA requires that you contain recommendations regarding the project in your report. When the final report is available you can consider any options and recommendations in that report, or any recommendations made by CMS outside of the framework of the report. It's possible, as I said, there will be no recommendation for the future of the demonstration actually contained in the final report but there may be one made by CMS at the same time in parallel.

You may wish to consider both recommendations, other alternatives, the CMS continuing work on frailty and the risk adjustment system and other factors.

Thank you. I'll take questions.

MR. HACKBARTH: The idea of demonstrations going on as long as these have troubles me, let me put it that way. I've got this thing about order. It seems to me that we don't want the demonstration process to be abused and become a vehicle for making higher payments or different payments to certain privileged organizations. So I would say there's a burden of proof that needs to be carried. That there's got to be, at some point in time, some reasonable evidence that these people are doing something new, unique, different, better that at some point in the future could benefit the entire Medicare program.

Based on what you've reported here, it doesn't seem to me that that standard of proof, that burden of proof has been carried, or anywhere near carried in these cases. In fact it's not even clear that they're enrolling a different population, which would be the starting point to show that you're doing something new and better for the frail elderly. You've got to have a different population. So I've got lots of reservations about this continuing and I guess my inclination would be to convert.

DR. ROWE: A couple of comments. Based on my experience with these kinds of things, this has several of the characteristics of long term clinical demonstrations based on the intuitive view that this must be better for patients. The two that come to mind, just from listening to your comments, are first, you always blame the doc when it doesn't work because the doc didn't integrate well enough with the case manager.

The second uniform finding in my experience is that when the evaluation doesn't show that it works, you blame the evaluation; so your comments about the evaluation was flawed and it wasn't

done right, there are questions about it.

The third, and final comment you'll be happy to know, is in my experience with these geriatric programs like the PACE program and the S/HMO and the comprehensive geriatric assessment programs, the determination of whether they work or not in the end in any large scale demonstration is very strongly influenced by the selection of the individuals who are put into this new methodology. Comprehensive geriatric assessment obviously works, but 20 studies showed it didn't because people weren't selected who were really likely to benefit from it. They weren't old enough, they weren't sick enough, they weren't on enough medications, they didn't have enough disability, et cetera, so you could never show benefit.

It's a design fault. It's the doctors, it's evaluation, and then finally when that fails it's a design fault.

So my question is whether or not -- not knowing enough about the S/HMO because I'm only 58 so I haven't been around as long as this demonstration. It was underway well before I graduated med school. But what if your sense, Tim, of how well targeted the intervention was to individuals who were likely to benefit?

MR. GREENE: The short answer is, I suppose it's not targeted to the frail. On the other hand, it was never intended to be. We classify S/HMO as one of the frail elderly programs, demonstrations. In fact it isn't, and as designed, as originally designed and described the demonstration was structured to avoid selection problems by deliberately going out to recruit a representative sample of beneficiaries. It was explicitly not designed as a program for the frail elderly and that's the way it's worked out, so we shouldn't be surprised.

DR. ROWE: So we shouldn't have this failure indicate that it doesn't work for the frail elderly, right?

MR. GREENE: Right, but it was never structured --

MR. DURENBERGER: I want to prove Jack's point about intuitive. I was in one of my son's garage in Minneapolis the other day, on Saturday looking for his power sprayer to clean my deck or something like that and he brought out this old box of plaques and he said, Dad, can I get rid of these damn things? Excuse me, darn things. So I started going through them and there's one that says, presented to me in about 1984 that said, the father of S/HMO.

[Laughter.]

MR. DURENBERGER: Also Jay Constantine who used to work for Herman Talmadge, he sent me out to San Francisco to look at this thing that became On Lok. So I'm the father of On Lok somebody told me. You look at PACE and you look at -- I was just at Evercare a couple weeks ago and they said, you're the father of the Evercare. I said, my God, I'm getting old, or I've been messing around fathering all these things.

But anyway, I agree with what the chairman said, why does it take 20 years to do it? But I just want to claim credit for the fact we're sitting here today talking about this.

MR. HACKBARTH: We should put you in charge of acronyms, too.

MR. DURENBERGER: We had one the same year called leaking

underground storage tanks. That was LUST. And we had zap the ZIP, that was trying to beat the nine-digit ZIP code. So the intuitive level at which we operated was a direct reflection on what many of us brought to bear on the subject.

DR. REISCHAUER: You know how they measure success in the Senate, when Dave takes responsibility for something that the evaluations show doesn't work and then says, this is a success.

[Laughter.]

DR. REISCHAUER: I was wondering, Tim, whether these entities charge premiums or have begun to charge premiums the way other Medicare+Choice plans do, or has the 5.3 percent been enough to tide them over these tougher times?

MR. GREENE: The only one of the four that charges premiums is the Kaiser plan in Portland. That's also the one that appears to have suffered adverse selection so it's not surprising. That's the short answer; no, with an understandable exception.

DR. WAKEFIELD: Tim, just two quick questions. I'm not very familiar with S/HMOs so are these plans primarily beneficiaries who reside in urban areas?

MR. GREENE: Yes.

DR. WAKEFIELD: Are they almost exclusively that?

MR. GREENE: Yes.

DR. WAKEFIELD: Then secondly, the beneficiary satisfaction data that you report, I'm following the health status and functional status data. For the beneficiary satisfaction --

MR. MULLER: [Inaudible.]

DR. WAKEFIELD: They do? Then I'm going to change my position on this, Ralph. Thank you for that heads-up.

The satisfaction data that were collected that are reflected on page four, I tracked on the health status and functional status data, but could you tell me the beneficiary satisfaction data you reported on page four, does that reflect both the phase one set of plans and phase two, or stage one and stage two, or are those satisfaction data collected on just one and not the other?

MR. GREENE: That's first generation plans, partly because the data was very limited in the 1980s and early 1990s at the time of that evaluation. By contrast, the data available for the second generation plan are more extensive data available in the late '90s and now. Secondly, there's a continuing survey of member health and functional status at the second generation plan.

DR. WAKEFIELD: So can you just tell me what is it, what are the beneficiary satisfaction data on the second generation plan? Is that far enough along that they have it?

MR. GREENE: I don't recall.

DR. WAKEFIELD: You don't recall. So they probably have some but we don't know what it is?

MR. GREENE: Yes. It's reported in the evaluation, I just don't recall because the focus has been on the outcomes measures as opposed to satisfaction so that's been researchers and my principal concern. I can certainly check the satisfaction information in the second report.

MR. HACKBARTH: Tim, MedPAC twice previously addressed this

issue, once in 1999, and once in 2000. I am a lawyer after all and so I'd like, if we're going to change course I'd like to be able to explain what's difference today from the year 2000, for example.

I haven't gone back and reviewed the text, but I am looking at the 2000 recommendations which are on page 11 of what's in our book. Reading between the lines here is an implicit endorsement of specialized plans that care for the elderly. Basically we say, tread carefully. Don't force them back into the regular payment system until it's clear that there is an alternative that meets the special needs of these programs.

Refresh my recollection about the conversation surrounding the 2000 recommendation and help me understand why I feel so differently today than apparently I felt then?

MS. RAPHAEL: I do remember that conversation and I think it had to do with the PACE programs which serve a dually eligible, frail elderly population, and it's a very different population from the S/HMO population.

MR. HACKBARTH: Yes, very different.

DR. NEWHOUSE: And Evercare also.

MR. HACKBARTH: But I remember, albeit vaguely, also talking about S/HMO in that same basket. I think those points are very well taken, Carol. I think PACE and Evercare are quite different programs and situations.

MR. GREENE: Several answers I suppose. First, you're correct we were talking about a whole range of specialized plans, frail elderly and otherwise.

DR. NEWHOUSE: We were asked to.

MR. GREENE: Yes, we were asked to. Now in this context and based on this mandate we're looking solely at the social health maintenance organization which, as I indicated, is a very different animal. So in that sense we had a different concern then.

Secondly, in terms of the 2000 recommendation, that was a report to Congress on risk adjustment, so it was a rather narrow, technical recommendation in the context of the initial PIP-DCG risk adjustment system.

MR. HACKBARTH: That's helpful. Any other comments on this?

MR. FEEZOR: Just for the record that when this issue comes up later I'll probably have to excuse myself. I think my organization has a financing relationship with one of them.

MR. HACKBARTH: I think we gave you a fairly clear direction on this one. Thank you.

MR. GREENE: See you in eight, nine months I suppose.